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Course Objectives

After studying the information presented, the reader should be able to:

- Discuss the major historical points related to the movement of the USA to a national healthcare system
- Define important terms used to discuss/describe portions of the Patient Protection and Affordability Act
- Provide rationale for the development of the Patient Protection and Affordability Act
- Describe changes to current insurance plans
- Discuss exceptions to the mandates in the insurance plans defined in the Patient Protection and Affordability Act
- Discuss elements of Section 1182 of the Social Security Act as they relate to the Patient Protection and Affordability Act
- Identify and briefly discuss models of care as a result of the transformation of care in acute care facilities
- List changes expected of patients as a result of care transformation
The Patient Protection and Affordable Care Act and
The Impact on Healthcare Delivery

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The Patient Protection and Affordable Care Act and
The Impact on Healthcare Delivery

For nearly one hundred years, U.S. Presidents have struggled with the complicated
politics of health care reform and universal health insurance.

Robert Mc Roberts on Sep 10, 2009

I. History of Health Insurance/Healthcare System in the United States

For most of us today, health insurance, in one form or another, has been a
regular and expected part of our lives. We have watched as the cost of health
insurance continued to rise and as insurance plans were developed, manipulated
and restructured in an attempt to develop products that would meet the needs of
the vast majority of customers. For close to 100 years, many have searched for
that elusive product that would provide basic, affordable healthcare coverage for
all.

From 1900-1920, those who were ill were generally cared for in their homes.
Since there was minimal availability of medications and procedures, there was
minimal cost incurred for care that was provided. However, reacting to signs in
the economy indicating healthcare costs were beginning to increase, Theodore
Roosevelt included the creation of a national healthcare program in his platform
as he campaigned for the office of President (1912). The plan that was offered
was to provide universal health insurance to all Americans (Milikis, 2012).
Historically, this was the first time a national healthcare plan was presented as a
part of the federal government responsibilities. This would seem to validate the
position that healthcare is not a right guaranteed under the Bill of Rights or any
other governmental document that includes information on the rights of American
citizens. If healthcare was a guaranteed right, one might have expected a
national healthcare plan much earlier in our history. Perhaps that issue needs to
be addressed as an essential first step in trying to institute a national healthcare
plan.

Roosevelt did not win that election. He was defeated by Woodrow Wilson who,
as president, did not lend the support needed to get health care legislation
passed by congress. Prior to 1920, many people felt actual health insurance (as
opposed to sickness insurance) was unnecessary and did not support
candidates/proposals which sought to impose “compulsory, nationalized health
insurance” on the American people (Thomasson, 2010). However, a type of
insurance to cover lost wages of the bread-winner if he/she became ill was
purchased by some so a family would continue to have needed income. One
study completed in Illinois in 1919 found that “lost wages due to sickness were
four times larger than the medical expenditures associated with treating the
illness” (Thomasson, State of Illinois, pp. 15-17).

There continued to be hesitancy by insurers to consider offering health insurance
as it was believed health was an “uninsurable commodity because of the high
potential for adverse selection and moral hazard” with people taking more risks
once they were insured (Thomasson, 2010). It was said that “Health and
sickness are vague terms open to endless construction. Death is clearly defined;
compensation is no easy task” (Insurance Monitor, 1919).

During this period of time, physicians opposed any move to introduce health
insurance by the government as they believed this would give the government
the opportunity to set ranges for fees received for care provided. Many would
now say this fear has become a reality as insurances (Medicare, Medicaid) have
fee limits determined by the government. And, as we will learn, more of this
governmental control will be implemented as a part of the Patient Protection and
Affordable Care Act (PPACA).

Changes in life styles beginning in the 1920’s began to create a need for health
insurance as people started working outside the home to a greater degree
leaving no one there to provide the care a sick person needed. Additionally, there
were advancements being made in the practice of medicine which encouraged
people to go to doctors and hospitals for treatment as hospitalization was now
seen as effective for bringing about a state of wellness to many (Thomasson,
2010). It was also during this period that the education of physicians was being
standardized and improved and standards for hospital care were being
developed so patients could expect appropriate levels of care at these facilities
(Thomasson). Healthcare costs were beginning to take a significant portion of the
family budget and people were looking for ways to reduce these costs.

Businesses across the country developed prepaid hospital service plans allowing
families to gain some control over what was being spent for healthcare. These
plans proved to be helpful for both the consumer and the hospitals, particularly
during the Great Depression. The plans “allowed consumers to affordably pay
for hospital care, and also benefited hospitals by providing them with a way to
earn income during a time of falling hospital revenue” (Davis & Rorem, 1932).
These various prepaid plans ultimately “combined under the auspices of the AHA
(American Hospital Association) under the name Blue Cross (Reed, 1947).
It is interesting to note that the Blue Cross plans were designated as non-profit organizations since they "often provided benefits to low-income individuals (Eilers, 1963). This was likely the foundation of what was to become the Medicaid program which was developed 20+ years later. To protect themselves from competition with Blue Cross, as well as to provide an alternative to compulsory insurance, physicians began to organize a framework for pre-paid plans that covered physician services. This resulted in the development of the Blue Shield plans which offered medical and surgical benefits for hospitalized members, although certain plans also covered visits to doctors' offices (Thomasson, 2010). Patients who purchased Blue Shield coverage were charged the difference between what was reimbursed by Blue Shield and the actual charge for medical services.

This brings us to the time of the Presidency of Franklin Roosevelt, the Great Depression and World War II. While many might have thought that this would have been a good time for passing national healthcare, the economy and unemployment insurance needs were foremost in the minds of legislators (Palmer, 1999). Work was also being done to address the insurance needs of the growing elderly population and the Roosevelt administration did not want to jeopardize that work by including a national healthcare proposal as part of his program (Palmer, 1999). During FDR’s second term, the National Health Act of 1939 was developed. This bill “gave general support for a national health program to be funded by federal grants to states and administered by states and localities” (Thomasson, 2010). However, the election of 1938 resulted in a return to conservatism and the National Health Act of 1939 was not adopted (Thomasson).

In the early 1940’s, others began to get into the insurance market when noting the success of Blue Cross/Blue Shield in avoiding adverse selection of customers by focusing on “providing health insurance only to groups of employed workers. This allowed commercial insurance companies to avoid adverse selection because they would insure relatively young, healthy people who did not individually seek health insurance” (Thomasson, 2010). This was the beginning of the current expectation to have some level of health insurance as a part of an employment benefit package. While this was a great way to become insured, this did create another difference between the ‘haves and have-nots’ which is now attempting to be addressed by the implementation of the PPACA.

An additional factor that led to the success of Blue Cross/Blue Shield while also leading to what some consider as problematic today is that Blue Cross/Blue Shield was able to “charge sicker people higher premiums than healthy people"
(Thomasson, 2010). This resulted in the ability to offer lower premiums to healthy employment groups and to gain the majority of group health insurance business at that time.

Employers also benefitted from these low premium programs as this allowed them to offer health insurance during the labor shortage created by World War II when employers were not able to increase wages to use as a recruitment tool. This use of health insurance as an employment benefit led to the 1949 decision by the National Labor Relations Board to rule in a dispute between the Inland Steel Co. and the United Steelworkers Union that the term "wages" included pension and insurance benefits. Therefore, when negotiating for wages, the union was allowed to negotiate benefit packages on behalf of workers as well. This ruling, affirmed later by the U.S. Supreme Court, further reinforced the employment-based insurance system.

Harry Truman became president (1945-1953) and was known to be a strong supporter of national health insurance. He wanted a “single, universal, comprehensive health insurance plan” (Poen, 1989). However, priorities were given to the Cold War and related issues. This allowed the conservative opposition to gain strength for their position to never allow ‘socialized medicine’ to become a reality. America would continue to have a system of private insurance for those who could afford it and public welfare services for the poor. As stated by (Poen), “discouraged by yet another defeat, the advocates of health insurance now turned toward a more modest proposal they hoped the country would adopt: hospital insurance for the aged and the beginnings of Medicare”.

The Eisenhower administration (1952-1960) did not develop any significant proposals for government-sponsored health insurance to address the needs of the country as a whole. It is felt those legislators who supported the passage of government-sponsored health insurance decided that the only way to begin to get to their goal was to incrementally enact pieces of a national-based healthcare system (Marmor, 2000). The first piece to be addressed was care of the elderly as proposed earlier by the Truman administration. This resulted in the creation of Medicare which was ultimately voted into law in 1965 as a part of the Johnson Presidency.

Medicaid, implemented in 1966, was developed as a federal-state program to provide benefits for the indigent. The federal part of Medicaid is to determine the minimum standards for Medicaid and the state portion of Medicaid is to determine eligibility and benefits that will be provided within the standards developed by the federal government. This division and joint responsibility for
the Medicaid system is one of the many aspects of PPACA that were challenged as the original presentation of the PPACA required states to expand Medicaid services. A Supreme Court decision on the legality of this mandate over-turned the essence of what was intended by the PPACA holding to the original role of the states regarding the Medicaid program. States cannot be mandated to expand their Medicaid program.

Both of these programs (Medicare and Medicaid) have grown in expenditures beyond what was anticipated when they were developed. Changes in the way Medicare was reimbursing providers as well as a growth in the aging population are factors in this rapid growth in expenditures. Regarding the growth in Medicaid, the eligibility requirements were lowered in the 1990’s, making the program available to many more people. “By 2001, Medicare and Medicaid together accounted for 32 percent of all health care expenditures in the U.S.” (Thomasson, 2010)

The Clinton Presidency (1993-2001) put forth significant effort to create a healthcare payment and service system that was to be a national system addressing the total population. As the nation's First Lady, Hillary Clinton was asked by the President to chair the Task Force on National Health Care Reform (1993). She was a leading advocate for expanding health insurance coverage, ensuring children are properly immunized, and raising public awareness of health issues (Whitehouse, ND). In addition to the standard responses from the conservative side of the government regarding national healthcare, there was now the additional concern regarding why a ‘first lady’ would be asked to chair such an important committee. Ultimately, there was not as much achieved regarding national healthcare as hoped when Clinton took office.

The Presidency of Barack Obama (2009-present) has led to the successful adoption of legislation that creates a national healthcare system, encompassing all American citizens. Implementation of some of the system components has been initiated while multiple challenges to portions of the legislation continue to occur. Many believe the essence of the PPACA legislation will remain while some components will be revised and/or removed. With implementation scheduled to occur through 2020, it is expected that several changes to the original legislation will be made.

An example of the changes to the original legislation occurred in the first week of July (2013). “The Obama administration said yesterday it would not require employers to provide health insurance for their workers until 2015, delaying a key provision of President Barack Obama's healthcare reform law by a year, to
beyond the next election” (Crain’s, 2013). This was considered a key component of the law but was receiving significant ‘challenges’ from businesses so the decision was made to delay this aspect of the program. As stated above, additional changes are expected to occur as the rules and regulations to implement the various aspects of the law are developed.

This history demonstrates how long the issue of a national healthcare insurance system has been considered and debated in this country. One has to look at this time frame and ask-if something is considered but never enacted for 100 years, is there reason to believe it is not the right thing to do? Or is it something that is important to do since it has been as a significant issue for such a long period of time.

II. Definitions

A. Pre-existing Condition - When discussing health insurance, a Pre-existing Condition is a diagnosed medical condition that one has prior to being insured by a new company.

B. Medicare-is a national social insurance program, administered by the US Federal government since 1965. This program guarantees access to health insurance for Americans aged 65 and older and younger people with disabilities as well as people with end-stage renal disease (Medicare.gov, 2012) and persons with Lou Gehrig’s disease.

C. Medicaid-is the United States health program for families and individuals with low income and resources. The Health Insurance Association of America describes Medicaid as a "government insurance program for persons of all ages whose income and resources are insufficient to pay for health care" (HIAA, pg. 232)

D. Individual Mandate - An individual mandate is a requirement by law that certain persons purchase or otherwise obtain goods or services.

E. Donut Hole - When discussing Medicare, the donut hole is the Part D coverage gap that lies between the initial coverage limit and the catastrophic-coverage threshold in the Medicare Part D prescription-drug program administered by the United States federal government. After a Medicare beneficiary meets the initial coverage limits of the prescription-drug plan, the beneficiary is financially responsible for a higher cost of
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The following questions and answers are provided for Review Only and may be referenced when completing the online exam.

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1. The first presidential candidate (recorded) to include a national healthcare program for this country in his/her campaign platform was:
   
   A. Franklin D. Roosevelt  
   B. Woodrow Wilson  
   C. George W. Bush  
   D. Theodore Roosevelt

2. A need for the general population to have some form of health insurance became apparent in the 1920’s because:
   
   A. More people began working outside the home.  
   B. The government required each family to have some basic health insurance.  
   C. Physicians required patients to have some form of guaranteed payment.  
   D. Health insurance was becoming a benefit for employed individuals.

3. The National Care Act of 1939 was developed. This supported a national healthcare program to be funded by ___________ and administered by ________________ and __________________.
   
   A. taxes; Blue Cross and states  
   B. grants; states and localities  
   C. taxes; states and localities  
   D. grants; physicians and governors

4. Medicaid was implemented in ____________ as a program for the______________?
   
   A. 1966; immigrants  
   B. 1966; indigents  
   C. 1976; indigents  
   D. 1976; immigrants
5. Medicare is a national social insurance program. This program guarantees access to health insurance for _______________ and _______________.

A. Americans aged 65; younger people who are unemployed  
B. Americans aged 65; indigents  
C. Americans aged 65; younger people with disabilities  
D. Americans who are retired; younger people with disabilities

6. The Donut Hole (Medicare) includes all of the following EXCEPT:

A. a coverage gap between initial limits and the catastrophic limits  
B. financial responsibility of the beneficiary during the gap period  
C. is included as part of Part D  
D. beneficiary having an income greater than the current poverty level

7. The Patient Protection and Affordable Patient Care Act include all of the following EXCEPT:

A. an implementation schedule running from 2010 to 2030  
B. passage into law by a vote of 60-39  
C. over 2000 pages of information  
D. perception that this is a great accomplishment of President Obama

8. The current (2013) defined time-line for future implementation includes:

A. January, 2017-Uninsured’s maximum penalty goes to $985.00 annually  
B. January, 2030-recommended cuts to Medicare can be implemented  
C. January, 2014-Health exchanges must be in place  
D. January, 2015-Medicare Advisory Board created

9. Practicing evidence-based, standardized care should result in _______________ with _______________.

A. maximum response to that care; minimal hospital stay  
B. maximum response to that care; minimal errors  
C. pre-defined response to that care; minimal errors  
D. pre-defined response to that care; minimal hospital stay
10. Moving from a physician-centered model of care to a patient-centered model of care should lead to all EXCEPT:

A. reduced costs of care
B. higher expectation for patient compliance
C. reduced need to access care because of compliance levels
D. reduction in the number of physicians needed in the healthcare system

11. The Exceptions to Requirements to Have Insurance include all of the following EXCEPT:

A. an undocumented immigrant
B. You do not file an income tax return due to low income.
C. prisoners
D. healthy young adults who choose not to be covered

12. The introduction of the Hospitalist physician-specialty of practice has brought about a demonstration of all EXCEPT:

A. the development of a set of standardized protocols for specific diagnoses
B. the importance of moving care to the bedside
C. the ability/opportunity to take direct action when a patient need is identified
D. a change in the way nursing staff are scheduled

13. The Patient Centered Medical Home is described as having the following characteristics:
   1. community-based
   2. program for Medicaid patients
   3. partnership between patients and providers
   4. comprehensive care

   A. 1, 3, 4
   B. 1, 2, 3
   C. 2, 3, 4
   D. 1, 2, 4
14. Patient compliance is a necessary component of transforming healthcare services. Some of the reasons for noncompliance are:
   1. cost of being compliant
   2. not involved in the development of the plan of care
   3. lack of understanding of what they are to do
   4. does not accept “following orders”

   A. 1, 3, 4
   B. 1, 2, 3
   C. 2, 3, 4
   D. 1, 2, 4

15. Several aspects of the PPACA have already been implemented. All aspects listed below have been implemented EXCEPT:

   A. Children can stay on their parent’s policies until age 26
   B. Health insurance policies cannot be cancelled due to illness or injury
   C. The income tax deduction for medical expenses increases from 7.5% to 13.5%
   D. New tax credits to subsidize premiums for low income earners

16. There are four standardized health insurance plans from which to select if buying your own policy. These plans are named:
   1. Bronze
   2. Platinum
   3. Silver
   4. Diamond

   A. 1, 3, 4
   B. 1, 2, 3
   C. 2, 3, 4
   D. 1, 2, 4

17. On January 1, 2014, many in the country will continue to receive insurance through an employer. This insurance can 'cost' the employee no more than _____% of income.

   A. 4
   B. 20
   C. 8.5
   D. 9.5
18. On January 1, 2014, health exchanges must be in place and be ready to sell mandated insurance products. Each state must offer:

A. a plan from Blue Cross/Blue Shield  
B. one plan offered by a non-profit entity  
C. one plan that does not provide coverage for abortions beyond those permitted by federal law  
D. at least two multi-state plans  

19. The Patient Protection and Affordable Care Act (PPACA) mandates the essential health benefits (EHB) that must be included in every health plan. These EHB’s are:

1. Hospitalization  
2. Preventative and Wellness Services  
3. Chronic Disease Management  
4. Oral and Vision Care for Adults  

A. 1, 3, 4  
B. 1, 2, 3  
C. 2, 3, 4  
D. 1, 2, 4  

20. It is estimated that the majority of Americans who buy health insurance on their own will qualify for a government subsidy to help off-set the cost of that insurance.

A. True  
B. False  

21. Information required to apply for a government subsidy includes all EXCEPT:

A. verification of birth records (Social Security Offices)  
B. verification of income (Internal revenue System)  
C. verification of driver’s license/identification (Motor Vehicle Department)  
D. verify immigration status (Homeland Security)  

22. Several new models of care are being introduced throughout the country as provision of care is being transformed. The model in Minnesota is Population Health confirming the need to improve the health of an entire population. The major elements addressed in this model are:

1. Environment  
2. Social structure  
3. Employment  
4. Resource distribution
23. The changes to Medicare as a result of the PPACA include all EXCEPT:

A. phasing out of the donut hole over a ten year period of time  
B. no longer allow the use of Medicare Supplemental Insurance  
C. changes to the method of reimbursement for Medicare Advantage plans  
D. an annual physical at no cost to the patient

24. Section 1182 of the Social Security Act is often referred to as the Death Panel section. Section 1182 defines the relationship of clinical effectiveness research to care decisions. The criteria to follow includes:
   1. Using research indicating the treatment will likely yield effective outcomes.  
   2. Only use evidence and findings from research conducted under section 1181 for coverage determination.  
   3. Use information from Hospice assessment regarding likely effective outcomes.  
   4. Consideration of being terminal can be used in the decision making process

A. 1, 3, 4  
B. 1, 2, 3  
C. 2, 3, 4  
D. 1, 2, 4

25. Partial funding of the PPACA will come from additional tax revenues as a result of changes to tax law. These changes are listed below EXCEPT:

A. Increase in sales taxes in each state  
B. Increase in taxes for single persons who earn greater than $200,000 per year  
C. New tax on capital gains above $250,000 (married couple)  
D. Eighteen additional new taxes to be implemented over the next seven years
26. The Medicaid program is expanding as a result of the PPACA, even though expansion is voluntary at the state level. As of the writing of this booklet, _____ states have agreed to expand Medicaid coverage:

A. 25  
B. 13  
C. 49  
D. 26

27. Life expectancy is closely related to states of wellness and disease prevention. The population in the United States demonstrates the effect of a lack of focus on wellness. The evidence to support this is the fact that the US is _________ in the world in life expectancy and this includes _______ socio-economic lines.

A. 41st, lower  
B. 35th, higher  
C. 41st, all  
D. 35th, all

28. Accountable Care Organizations are groups of providers that agree to be accountable for __________, ______________, & _______________ of a defined group of Medicare beneficiaries.

A. cost, quality, overall health  
B. cost, quality, overall care  
C. cost, wellness, overall care  
D. cost, wellness, overall health

29. Family-centered Care avoids separating patient and family while the patient is hospitalized. The value of this to the overall treatment/care of the patient is all EXCEPT:

A. families learn how to care for the patient upon discharge by being involved while Hospitalized  
B. families provide support  
C. families reduce the workload of the hospital staff  
D. families reduce the number of patient falls
30. Community education is an important step in the transformation of healthcare. This education should accomplish all the following EXCEPT:

A. formal education for degree completion
B. better understanding of what to expect from the healthcare system
C. resources to help achieve healthy life styles
D. sharing of information on powers-of-attorney for healthcare decisions and end-of-life decisions

31. Caramenico (Addendum B) states hospitals are already achieving cost savings. She provided the following statistics supporting this achievement:

A. 450 hospitals and physician groups joined accountable care programs.
B. In New York City, ER visits fell 60%.
C. Readmissions to hospitals fell by 56%.
D. In New York City, ER visits fell 54%.

32. In an article by MacDonald, entitled, Obama dismisses GOP critics, says healthcare reform working as planned, several examples of ‘success’ of the PPACA are given. These examples are:
1. Californians have 13 insurance companies from which to choose coverage.
2. Premiums are lower than expected.
3. There are tax cuts and tax credits to help people afford the insurance.
4. Marketplaces in Michigan, New York and Minnesota are offering affordable premiums.

   A. 1, 3, 4
   B. 1, 2, 3
   C. 2, 3, 4
   D. 1, 2, 4

33. The PPACA influences the provision of healthcare as we know it today. The following statements describe areas that are expected to be directly impacted with the implementation of the PPACA:
1. scheduling physician appointments
2. level of compensation for Radiology Technologists
3. availability of physicians
4. current models of care delivery

   A. 1, 3, 4
   B. 1, 2, 3
34. Virginia Mason Medical Center in Seattle, WA experienced a transformation of the way in which care and services were being provided. A key component of this transformation was the recognition and implementation of the philosophy that the 'distance' between management and care providers needed to be increased.

A. True
B. False

35. Makary believes the desired quality in the provision of healthcare will only occur when there is true transparency in the system. An example cited in his book (Unaccountable) describes the need to have ___________ ___________ between the patient and practitioner.

A. confidential; conversations
B. regular; appointments
C. open; notes
D. complete; honesty